



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF INFORMATION SYSTEMS
P.O. Box 570, Jefferson City, MO 65101-0570

HELP DESK LOG #
(Assigned by OIS)

NETWORK USER ACCESS REQUEST

SOCIAL SECURITY NUMBER		OFFICE TELEPHONE	
NAME (Last Name, First Name, MI)		BUREAU/SECTION/UNIT	
DIVISION DCPH/CFNA Unit - CACFP		SUPERVISOR'S NAME	
WORK LOCATION (Street, City, Zip)		COUNTY	

WORKSTATION INFORMATION

<input type="checkbox"/> PC - DHSS Property Tag # for CPU: _____	IS THIS AN EXISTING PC REASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Laptop Computer (PC) - DHSS Property Tag #: _____	IS THIS A NEW MACHINE INSTALLATION? * <input type="checkbox"/> YES <input type="checkbox"/> NO
(*Access form must be for the person receiving the PC)	
Include PO# for new machine in the Comments section.	

NETWORK ACTION REQUESTED

<input type="checkbox"/> ADD NEW USER ID – Start Date: _____	<input checked="" type="checkbox"/> ADDITIONAL NETWORK ACCESS <i>(List drive letter and folder name(s) in comments below)</i>
<input type="checkbox"/> NAME CHANGE – Former name: _____	New Name: _____
<input type="checkbox"/> TRANSFER <i>(Requires 2 forms, one from both new and old Bureau or Division)</i> - Home directory copied to: _____	
<input type="checkbox"/> DELETE USER ID <i>(Only if the user is no longer employed by DHSS)</i> Effective Date: _____ Home directory copied to: _____	

SOFTWARE ACTION REQUESTED

Missouri Department of Health and Senior Services Employees with compatible computer equipment will automatically be given access to the DHSS standard applications. These include: Microsoft Office 2000 (Word, Excel, Access, and PowerPoint), Internet Explorer and Email.
Installation or removal of any other software applications must be requested below.

ACTION REQUESTED: ☐ ADD ACCESS ☐ DELETE ACCESS TO THE FOLLOWING APPLICATIONS

OIS SUPPORTED APPLICATIONS

NOTE: OIS will provide Help Desk support for supported applications.

☐ Microsoft Office 2000 ☐ Email ☐ Internet Explorer

3270 (MAINFRAME/PRODUCTION)

_____ # of 3270 Sessions

(a DDP-137 security form must also be filled out and attached for any 3270 access)

SPECIALIZED APPLICATIONS/DATABASES

☐ SAS ☐ Aspen ☐ Other (Specify) _____

DHSS DIAL-UP/REMOTE GROUPWISE

(you must have a modem in order to utilize the DHSS Dial-up and Remote Groupwise functions)

☐ DHSS Dialup ☐ DHSS Dialup/Network Drives ☐ Remote GroupWise

NON OIS SUPPORTED APPLICATIONS

NOTE: OIS does not provide Help Desk support for non supported applications and proof of license must be given to technician before install. Some applications will require special approval and/or a DDP-137 form.

☐ Other _____

☐ Other _____

☐ REGISTER DIGITAL CERTIFICATE/TOKENS/KEY FOBS WITH OIS

Digital Certificate Serial Number: _____

Issuing Authority: _____

Issue Date: _____ Expiration Date: _____

COMMENTS (Use back for more space.)

Provide claims access to the CACFP Online Claims Submission application.

Email address: _____

I, the undersigned, an employee of State of Missouri or authorized user of DHSS data, understand that approval and assignment of the requested ID or approval of the requested change enables me to access the resources, which by law, must be utilized only in the performance of my assigned duties. Therefore, I agree to make no inquiries or updates which are not required in the performance of my official duties. I understand that state and federal statutes require confidentiality of information and provide penalties for unauthorized access, use and/or disclosure of information. Violations or disclosures on my part may result in disciplinary action that could be one or all of the following: (1) suspension, (2) civil court; and (3) dismissal. I agree to keep confidential all information made available to me in the performance of my official duties. In addition, I agree not to divulge or share my passwords with anyone.

USER SIGNATURE *(Required)*

DATE

➤

SUPERVISOR SIGNATURE *(Required)*

DATE

➤

OTHER APPROVAL SIGNATURE *(If Needed)*

DATE

➤

FOR OFFICE OF INFORMATION SYSTEMS USE ONLY

DATE RECEIVED:

Instructions to Request CACFP Online Claiming

The Missouri Department of Health and Senior Services (MDHSS) –Community Food and Nutrition Assistance Unit has web-based online claim submission. This allows submission of the monthly Child and Adult Care Food Program (CACFP) claim via the Internet. The system has built in edit checks that minimize the possibility of the claim being returned for errors.

Internet claims submission is required as of October 2005. In order to participate, please complete and sign the Network User Access Request form. **Only the following sections need to be completed:**

<u>Section</u>	<u>Information Required</u>
• Social Security Number	Social Security Number of User
• Office Telephone	Facility Telephone Number
• Name	Name of User to which ID & Password will be Assigned
• Bureau/Section/Unit	Name of your Facility
• Supervisor's Name	Immediate Supervisor <i>OR</i> Owner or Board Chair
• Work Location	Facility Address
• County	County of Facility
• Comments	E-Mail Address of User, if available
• User Signature	User Signature
• Supervisor's Signature	Immediate Supervisor <i>OR</i> Owner or Board Chair Signature

We will notify you when our Office of Information Systems (OIS) has established your User ID and password. This process could involve up to a two-month time period from the time we receive your Network User Access Request form until the OIS has established your User ID and password and you are granted access. Please be advised that your User ID and password must **NOT** be shared with anyone, as stated on the Network User Access Request form. Please note the importance of protecting your user ID and password, as you are responsible for any and all claims submitted under your user ID. You must notify us immediately if there are staff changes in order to remove access and grant new access for the new user.

Please mail the original, completed access form to:

Missouri Department of Health and Senior Services
Community Food & Nutrition Assistance
Attention: Beth Thompson
PO Box 570
Jefferson City, MO 65102

You may also fax a copy of the form to 573-526-3679. If you have any questions, feel free to call Beth Thompson at 1-800-733-6251.